

## საბაზრო მექანიზმები და ჯანდაცვის სერვისების მიწოდება

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*ნაშრომი მიმოიხილავს ე.წ. „ნახევრად-ბაზრების“ დანერგვასა და განვითარებას გაერთიანებული სამეფოს ეროვნული ჯანდაცვის სისტემაში. ნახევრად-ბაზრები წარმოადგენს ერთ-ერთ საბაზრო მექანიზმს, რომლის დანერგვაც დაიწყო 1990-იან წლებში და რომლის თანახმადაც მოხდა ჯანდაცვის სერვისების მყიდველებისა და მიმწოდებლების გამოჯვანა. ნაშრომში იკვლევს სანახევროდ-ბაზრების სარგებლიანობას ჯანდაცვის სერვისების მიწოდებაში. სარგებლიანობის განსაზღვრა ხდება ხუთი ძირითადი კრიტერიუმის მიხედვით: ეფექტიანობა, თანასწორობა, ხარისხი, არჩევანის შესაძლებლობა და ანგარიშვალდებულება. შესაბამისად, თოთოეული კრიტერიუმის გაუმჯობესება ან /და გაზრდა განიხილება, როგორც სარგებლიანობის ზრდის მაჩვენებელი.*

## Can Markets Benefit Public Health Services?

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Since the establishment of the NHS in 1948 until recently, by far the largest part of the UK health care had been provided by the public sector. The decisions how much should be produced and how this production should be allocated were made not by ‘self-interested’ individual producers and consumers competing with each another but by politicians and professionals operating in a bureaucratic environment (Le Grand and Bartlett, 1993, p. 1).

Because of the sensitivity attached to health and health care, traditionally it was considered unethical to apply economic analyses to it (Le Grand, Propper & Robinson, 1993, p36). Even under the Thatcher government obsessed with the introduction of the market style mechanisms into welfare provision, the health care system remained largely intact until the late 1980s (Le Grand and Bartlett, 1993, p. 2).

The “big bang” occurred with the reforms of the late 1990s, when the government introduced internal or quasi-markets into the health care, under which the purchasers and providers were separated (Le Grand, 1991, p. 1258). The key words of the reforms were choice and competition, choice for patients, and competition among providers. The underlying rationale was that competition would compel providers to be more efficient and more responsive; otherwise, they would be forced to leave the market (Klein, 1998).

However, the health care system came under scrutiny once again when the Labour government came to power and officially abolished internal markets with the publication of the White Paper in 1998 (Le Grand, 2002). The purchaser/provider split was retained but the system based on competition was replaced by the system “based on cooperation;” and collaboration and contestability became new key words (Klein, 1998).

These developments raised many questions that have been hotly debated. Why the reorganization again? Did internal markets prove unable to provide any improvement to health services? Can they generally benefit public health services?

To answer this questions, the paper provides theoretical as well as empirical considerations. Namely, I will examine the origins of the internal markets and theoretical speculations about the potential benefits they might have and then I will test these speculations against empirical data from the UK experience.

### *Understanding the Quasi-Market Phenomenon*

The reforms to the NHS, outlined in the Working for Patients, came into legislation on 1 April 1991 in the form of the Community Care Act. However, the origins of the reforms can be traced back to the early 1980s, when Mrs. Thatcher created an environment, which “valued wealth above welfare, markets above bureaucracies, and competition above patronage” (Butler, 1993, p. 14).

There are many explanations for the introduction of the internal markets. The policy climate under the Thatcher government along with the growing criticism of the NHS in terms of micro-inefficiency (Barr, 2004, p. 286) were two main factors that eventually led to the introduction of the quasi-markets (Bartlett and Harrison, 1993, p. 69). Central to Mrs. Thatcher’s philosophy was that monetary control and competition were main tools for controlling macro- and micro-economy, respectively. The competition was deemed necessary to generate constant pressure for efficiency and keeping prices down. The state was believed to have no place in the market and therefore public sector monopolies became the target for change through privatization - selling off major state assets to private sector shareholders (West, 1997, p. 2).

While it was easier for the government to get rid of public monopolies in industries such as transport, energy, telephone and so on, it was not the case in education and health, services believed to be ethically sensitive. "If privatization was not an option in the achievement of better performance in health and education, policy needed to find other ways of achieving uniformly high efficiency" (West, 1997, pp. 2-5). So, the offer was "competition without privatization", i.e. establishment of the purchaser-provider split, a suggestion of an influential critical analysis of the NHS by the American health economist Alan Enthoven (Glennerster, 1997, p. 187).

Glennerster notes that the quasi-market was a solution to the failure of both market as well as government in meeting needs and wants in an efficient way. The basic idea was to keep services free at the point of use and finance them out of taxation, but let agencies compete to provide those services (Glennerster, 2003, p. 30).

The term quasi-market was coined by Williamson, although it is generally associated with the work of Le Grand and Bartlett (Powell, 2003). According to Le Grand and Bartlett the quasi markets are "markets" in the sense that they replace monopolistic state providers, and are "quasi" because they differ from conventional markets in a number of ways (1993, p. 10). On the supply side, there is competition between NHS Trusts (providers) and on the demand side consumer purchasing power is exercised by GP Fundholders and by DHAs (purchasers). The interaction between them is on the bases of contracts (Robinson and Le Grand, 1995, pp. 26-28).

#### *Evaluation of the internal markets in the Health Care*

To judge whether internal markets can benefit public health services, first we need to define what we mean by "benefit" and set out criteria against which quasi-market policy should be evaluated. Le Grand and May (1998) proposed five main criteria for this reason: Efficiency, equity, quality, choice and responsiveness, and accountability (pp. 15-17). Those criteria will be further used for evaluation and consequently, any increase and/or improvement of them will be considered as beneficial to health services. Our assessment is based on the theoretical as well as empirical considerations.

Predictions and theoretical speculations about the internal markets were mostly optimistic. It was recognized that contracting would lead to increased transaction costs, but still, it was believed that efficiency gains in service delivery due to competition would more than offset them (Robinson and Le Grand, 1995, p. 37). Commentators argued that internal markets might well benefit health services in terms of increased effi-

ciency, if they met certain conditions. The most important was that they should have been competitive (Le Grand and Bartlett, 1993, pp. 13-34).

However, the fulfillment of these conditions in practice proved difficult, if not impossible. The early empirical assessment, provided by Bartlett and Harrison on the bases of the Bristol and Weston Health authority case study, was disappointing. The lack of purchasers and providers led to the prognosis that quasi-markets are likely to fail to operate in a competitive fashion in many local areas (1993, p. 88). Later assessments of the reforms provide various results and it is worth discussing them separately according to our set of criteria.

### *Efficiency*

One of the main criticisms of the NHS before quasi-markets was that it was inefficient. Critics argued that the cost of services in a monopolistic public market was twice as high as in a competitive market (Boyne, Farrell, Law & Richard, 2003, p. 16). There are two definitions of efficiency proposed by economists: technical or productive efficiency and allocative efficiency. Technical efficiency is defined as the ratio of service "inputs" to "outputs" and usually measured by the "unit cost" – resources required to produce a "unit" of good or services. Allocative efficiency is the match between the outputs and preferences of the public and is mainly assumed by the purchaser side (Boyne, Farrell, Law & Richard, 2003, pp. 16-17).

According to Le Grand (1999), the CWAI is the only indicator on which the evaluation of the overall productive efficiency of the NHS could be based. The CWAI is obtained by aggregating the activity rise in various areas of hospital and community health services, each weighted by the proportion of resources they receive (DoH, 1996). Muligan (1998) examined the changes in the activity measured by the CWAI over the period before and after the introduction of internal markets and revealed that the activity started rising faster after the reforms. Moreover, there was a greater increase in activity than in real resources after the reforms (p.23), which means that the cost per activity decreased and consequently, the overall productive efficiency increased (Le Grand, May & Mulligan, 1998, p.120). Le Grand (1999) argues that the efficiency increased despite considerable increases in transaction and management costs. Even more, since the management costs are included in the overall costs of resources and the activity increased more rapidly than the resources overall, "any cost-inflationary impact from the increase in these costs was more than outweighed by other positive factors contributing to greater efficiency".

With respect to separate parts of the internal market, Goodwin (1998) assessed the technical efficiency of fundholders by using proxies such as prescribing cost, referral rates and savings (p. 45). Government

hoped to reduce wasteful prescribing costs and inappropriate referral rates by imposing budgetary pressure. Indeed, the data analysis undertaken by Hurriss and Scrivener (1996) showed that the English fundholders were more cost-effective prescribers than non-fundholders and they made greater savings than DHAs, although changes in referral rates were more difficult to observe since different studies suggested different results (Goodwin, 1998, pp.49-51). However, despite this kind of improvements, as Le Grand (1999) points out, studies do not show whether they outweigh any associated increase in costs or not, and therefore we cannot judge if the unit cost decreased, which is a proper definition of efficiency.

As for the allocative efficiency, there is no properly documented evidence to build a national picture (Mulligan, 1998, p.26), although there was a clear shift in the provision of care from the secondary to the primary level under the internal markets and GP fundholders appeared to serve as a catalyst in this process (Goodwin, p. 52).

### *Equity*

Striving for equity, “an almost universally recognized goal in health care” (Appleby, 1992, p. 13), was one of the principal motivations that led to the establishment of the NHS in 1948. Broadly speaking equity means equality of opportunity (Barr, 2004, p. 255), i.e. equal access to care for everyone on the basis of need regardless any other factors such as income, race, class, gender, etc. (Le grand, Mays & Mulligan, 1998, p. 76).

While other criteria were expected to improve under the internal market, the equity by contrast was feared to be eroded (Saltman and Van Otter, p. 9). However, some aspects of reforms, not directly concerned with the introduction of competition but rather related to the health promotion based on the assessment of needs, were heralded as beneficial in terms of equity. Namely, it was assumed that the assessment of needs would highlight inequalities in health and in provision and having purchasers as “champions of people”, who would use this assessment, as the bases for resource allocation, would eventually lead to a more equitable allocation of resources; so, “market could be used as a positive tool to achieve greater equity” (as cited by Whitehead, 1993, p. 214). However, there is no evidence available to back up this argument at the national level (Whitehead, 1993, p. 231). By contrast, there has been a growing concern that the market-oriented system is not compatible with equity principles and the main goal in this respect became to retain at least the same level of equity. So when evaluating the impact of the internal markets on equity, we need to examine whether improvements in other criteria, if any, take place at the expense of equity or not.

Two issues were widely discussed in relation to internal markets and its equity implications. First was the fear that the internal markets could lead to cream skimming – the deliberate selection of patients who were less costly to treat in order to protect budgets. However, there is no evidence that cream skimming took place under the internal markets, on either the purchaser or the provider side (Propper, 1998, pp.24-26; Le Grand, May & Mulligan, 1998, pp. 123-124; Le Grand, 1999). Second concern was the issue of so-called “two-tierism” whereby patients of GPFHs get preferential treatment over the patients covered by DHAs. Indeed, the evidence shows that better access to hospital care for GPFHs was more widespread (as cited by Dixon and Glennerster, 1995), however, Propper (1998) argues that these differences did not appear in response to the internal markets, rather they were determined by several other factors (p. 25). Furthermore, Le Grand, Mays & Mulligan (1998) claim that there is no evidence that internal markets resulted in patients of non-fundholdings being worse-off. Instead, quasi-markets achieved different rates of improvement for fund-holding and non-fundholding practices with better results for fund-holding patients, rather than absolute worsening for non-fundholding ones (p. 124). So generally, it is argued that quasi-markets did not sacrifice equity as feared by critics.

### *Quality*

The competition was also expected to improve quality and “give patients a better care”. However, how to measure quality in health care is debatable since the term itself is multi dimensional and might be subject to many possible interpretations (Le Grand, May & Mulligan, 1998, p. 17).

In a study of the impact of competition on quality by Propper, Burgess & Green (2004), the death rates from acute myocardial infarction is used as a measure of quality. By using cross-sectional analyses based on several measures of competition and the average death rate for each hospital for the period 1995/6-1997/8 they found out that the hospitals facing more competition had higher death rates, i.e. lower quality. In another study, Propper, Burgess & Gossage (2003) used the same measures for competition and quality and a panel data set of all acute hospitals in England from 1991 to 1999. The overall result was the same: the impact of competition was to reduce quality (pp. 19-20).

Le Grand (1998) proposed two other indicators of quality such as patients’ satisfaction and waiting lists. According to the annual survey of the public’s attitudes to the NHS conducted by the British Social Attitudes Survey, although dissatisfaction with the overall running of the NHS fell from 47% in 1990 to 38% in 1993, it went up again and reached 50% in 1996 the highest level ever (pp. 124-127). As for waiting lists, they were increasing steadily in length before and after the introduction of the in-

ternal market. However, the mean waiting times were falling during the same period i.e. people were waiting for shorter periods and by 1993 almost no one was waiting more than two years (Le Grand and Wizard, 1998, pp.99-101). Overall, the average waiting time did not change under the quasi-markets and was broadly the same as before (cited by Le Grand, May & Mulligan, 1998, p.127)

### *Choice and Responsiveness*

Another objective of the reforms, as set out in the Working for Patients, was “to give patients greater choice of services available”. It was argued that in the internal markets where providers, who compete with each other in order to secure contracts with purchasers, will have an incentive to attract patients and “money that follows them” and accordingly will make sure that they offer services which patients want (Mahon, Wilkin & Whitehouse, 1993, p.110). However, Mahon, Wilkin & Whitehouse, (1993) pointed out “if choice is expected to increase because of the introduction of a market ethos into the health service then disappointment is inevitable”. Indeed, the research project conducted at the early stage of internal markets and evaluating the impact of the NHS reforms on patients’ choices revealed little change during the first year of the reform (pp. 119-125). Later publications develop the same idea. According to Le Grand, May & Mulligan (1998) choice for patients did not increase under the internal marker, neither on the provider’s side, nor on purchaser’s side. With respect to responsiveness, the purchasers, namely GPFH, seem to have more success in obtaining responsiveness from providers but the overall change was also minimal (pp. 127-128).

### *Accountability*

As far as health services were still funded out of general taxation under the internal markets it seems rational that purchasers and providers need to account for their activities to the funders. Two forms of accountability were mainly discussed in this respect: accountability to the centre and accountability to the local community and patients (Le Grand and May, 1998, p. 17). Overall, according to studies, there was more improvement in the upward accountability on both purchasers and providers sides and the accountability of the HAs to the center was higher than that of the GPs. However, the concern about the lack of accountability was growing, and even after several years since the launch of the internal markets it was generally regarded that accountability procedures must improve (Goodwin, 1998, p. 66).

### *Conclusion*

Thus, from the discussion, we can see that there was some increase in efficiency, and what is important; the increase did not take place at the expense of equity. However, other criteria did not change much. Overall, there was little measurable improvement attributable to the internal market (Le Grand, 1999). Generally, the experiment was deemed to fail. However, some commentators still claim that the failure does not mean that internal markets cannot generally benefit health services; rather the failure was a result of the government's inability to create certain conditions necessary for internal markets to work properly. E.g., Klein (1998) argues that since it was the government, who was responsible for the consequences, it could not leave decisions to the markets so easily, which undermined the devolution of decision-making and impeded the establishment of competition -the central concepts of the market system. Le Grand (1999) goes even further, by claiming that in reality internal markets were never tried, instead there was a representation of one. The government simply "could not let go of the market that it had tried to set up" and consequently did not create proper environment for competition, the underlying condition for success; "In the battle between market competition and central control, control won".

Thus, from the discussion, we can conclude that in theory, internal markets can benefit health services in case certain conditions are met. However, it proved difficult to back up this argument by the empirical evidence from the UK internal market, since despite some improvements in terms of efficiency; the overall picture was mainly disappointing. Nevertheless, according to some commentators, the internal markets would have brought better results if they had been properly implemented. So generally it turns out that the failure was a result of inappropriate conditions which leads to the conclusion based on the initial prediction - internal markets can benefit public health services if they are implemented properly.



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